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ABSTRACT

Religious minorities, as well as ethnic and racial minorities, present specific clinical and treatment concerns. Counselors of Hasidic and Orthodox Jews should be aware of the special characteristics of these populations which separate them from other subcultures and subgroups, and which may play an important part in the psychotherapeutic process. A major problem in counseling both these groups stems from the Holocaust. Conditions such as postpartum reactions, symbiotic illnesses, and masochistic behavior may be encountered alone or in combination with other symptoms. Prior to treatment several issues must be addressed, including obtaining permission from the local Rebbe. Brief and highly dramatic therapy is often effective. Follow-up assignments may be helpful in channeling guilt feelings. The therapist must be aware of his/her own feelings about the Holocaust and be prepared to deal with the anger clients feel toward others. Children of Holocaust survivors also are a vulnerable group; therapists should ignore the survivor syndrome and examine the extent of loss felt by their parents. (JAC)

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Abstract

In general, counseling ethnic and racial minorities presents specific concerns and problems. However, religious minorities also present specific clinical syndromes and treatment concerns. This paper will focus on Hasidic and Orthodox Jewish Survivors of the Holocaust, their specific problems and make general recommendations for treatment.

Counseling may be a difficult proposition depending upon the client, the client's presenting problem, the resistance of the client, the age, sex, race, and duration, frequency and intensity of the problem. For some clients, their neurosis is an "old friend" that they do not want to abandon. For others, they may be fearful and apprehensive of changing their behaviors, and may not comply with the therapist. Other clients may have to undergo counseling by court order or through some form of coercion. In many instances, the race, sex, and culture of the client may be a major factor in the success or failure of the therapeutic effort. In other instances, socio-economic status, perceived inflexibility, and other issues may enter into the therapeutic crucible.

In some religions, the therapist is regarded as an outsider or a person who is attempting to inculcate the values of the larger society. In other cases, the client may be part of an out group or an actual minority, either numerically or by choice (eg. the Amish). In any case, these groups present specific difficulties in counseling and these issues will be addressed in this paper. The specific groups which I wish to address in terms of counseling are the Hasidic and the Orthodox Jewish groups which are essentially far removed from main Jewish orthodoxy and each of which present specific problems in terms of counseling. First of all, I wish to specify the specific features of a Hasidic group which separates them from other sub-cultures and sub-groups. These characteristics are:

1) The primary position of the Rebbe as leader of the community: His position at the pinnacle of a religious hierarchy.

2) Distinctive dress and the wearing of sidelocks by men and boys.

3) Strict adherence to every aspect of Halachic practice.

4) Strong resistance to outside influence (variable) and adherence to prescribed social and religious custom.

5) Inherent strong appeal of mystical and ecstatic experience (variable)

6) High level of Messianic expectation.

7) Very tightly knit family, kinship and group allegiances.

8) Strong magical folkloric and shtetl influences. (Siegal, 1980)

All of the above may play some part in the psychotherapeutic process. The Orthodox Jew, in addition, has several distinctive characteristics, which separate him/her from the Hasidic Jew. Many of these differences are religious in nature, and essentially revolve around a less strict religious environment and practice and more interaction with mainstream culture.

A major problem area in terms of counseling both of these groups stems essentially from the Holocaust, Hitler's attempt to exterminate the Jewish population during the Second World War. The repercussions and ramifications of the Holocaust are still being felt by the survivors, and the families of the survivors. First, an examination of the Survivors and their specific problems and counseling issues will be examined and then the second generation - the families of the survivors will be examined with their particular difficulties. Counseling issues will then be addressed.

Siegal (1980) has indicated the main conditions encountered when working with Survivors:

"1) Postpartum reactions. 2) Symbiotic illnesses and problems of individuation. 3) Chronic pain-dependent and overly masochistic behavior patterns (and masochistically tinged sexual fantasies). 4) Chronic paranoid-persecutory states. 5) Bizarre syndromes such as psychopathic

acting out, mocking and mimicry as central features of paranoid conditions, olfactory related conditions and shared delusional systems."

These main conditions may be seen either in isolations or in conjunction with other psychiatric symptoms. Prior to treatment, several issues must be addressed. First, as noted by Siegal (1980) "The Rebbe as leader of the Hasidic community, with awesome power of the word, endows any person he approves as doctor or therapist." Hopefully the counselor will have the approval of the local Rebbe, thus sanctioning treatment. Most Hasidic patients expect an "immediate cure". This sets the stage for very brief and possible highly dramatic psychotherapy as is often seen in Psychodrama and Gestalt.

The therapist uses certain specific therapeutic strategies such as "strong eye contact and fixation, repetitive phrasing and reminders of the rabbinic injunction" (Siegal, 1980). Furthermore, hypnosis, suggestion and parables are particularly effective with the Hasidic patient. In addition, expiatory activity for wrong doings are often assigned by the therapist. Rather than giving ultimatums or orders, the therapist can offer selections, options or alternatives to clients. With these techniques, the client is able to self-determine his/her destiny. Dream work is also an integral part of therapy with the Hasidic client. One client, treated by Siegal (1980) was told that her father "Dov Lazar", "would come to her in her dreams and guide her better than all of the physicians and rabbis." With this intervention, the patient self determined her own destiny and the emotional influence of the father was a highly therapeutic agent.

In order to channel any guilt feelings that may exist, follow up assignments may be given to patients. In another case treated by Siegal

(1980), the patient was advised to make "long and arduous trips to a nursing home to tend geriatric patients as a volunteer". This behavior replaced nightly cold showers as the client's act of expiation.

A more adaptive device to help Survivors cope is cited by Rustin (1980). He indicates that Jewish fraternal organizations "perpetuate a continuity with the past and compensate for the loss of the extended family."

In dealing with payment issues, note must also be taken. On one hand, the client may want to "see a big man" (hang up all your certificates and diplomas, counselors) and yet want to "bargain" with the therapist. Often Hasidic clients may proffer gifts, food and other items as a part of payment. As with all minority groups, "It is important that the therapist be attuned to the religious beliefs and customs of the Hasidic groups without presenting himself/herself as a threat to deeply held traditions" (Siegal, 1980). It is often important to reinforce held beliefs and minifest some knowledge as to religious customs and beliefs so as to establish and maintain rapport.

Particularly important in the treatment process may be the therapist's own awareness of his/her feelings regarding the Holocaust. Feuerstein (1980) indicates "While Survivors, their children or therapists working with aspects of the Holocaust cannot undo the terrible reality involved, how these events enter into the present and future conditions around them as well as within their inner life may be a vital part of success or failure in the therapy itself." The emotional pain, anguish and grief felt by Survivors and their loved ones is of crucial importance in the therapeutic process. Furthermore an attempted understanding of "the causes of the

Holocaust, and why the surrounding world did not hear the anguished cries of the tortured and why, when they were heard, it failed to act in a compassionate and human way." (Feuerstein, 1980)

Thus, there is much "unfinished business" to be dealt with as grist for the therapeutic mill. The anger felt toward others is often of major import.

There are also factual considerations which should be taken into account. Rustin (1980) indicates four distinctions: 1) the age of the Survivor during the period of internment. 2) the length of time that the Survivor was imprisoned. 3) the differences among internment in a slave labor camp, internment in a concentration camp and internment in an extermination camp. 4) the background of the Survivor and the culture the Survivor emigrated to after the war."

Barocas and Barocas (1973) have indicated that "probably no amount of psychotherapy can ever fully remove the scars inflicted on these people during their incarceration. It is reasonable to hypothesize that the price of survival for these people may have been deep-rooted disturbances within the families they formed after liberation.

At this point, another group shall be examined i.e. the children of concentration camp Survivors. Barocas and Barocas (1980) have indicated that these children "present a picture of impaired object relations, low self esteem, negative identity formation and considerable personality constriction. They also exhibit increased vulnerability in stress situations and pathological regression and some temporary blurring of ego boundaries when confronted with experiences reminiscent of the Holocaust."

Commonalities with these clients have been also noted by Siegal (1980) "both parents in concentration camps, maternal overprotection and over concern from their childhood, somewhat tentative, shy and immature character structuring." The above has been typically seen in women with post partum reactions.

In treating children of Survivors, several preliminary avenues should be explored. First, the stereotype notion of the "Survivor syndrome" should be ignored and a detailed anamenesis, if possible should be taken in order to ascertain if the client's progenitors do, in reality resemble the "typical" Survivor profile. Secondly, therapists must try to determine "the extent of the loss parents felt and whether or not they seemed preoccupied with depression and mourning when they raised their children" (Rustin, 1980). Information relative to the client's parents and their amount of emotional investment in their children, possible impoverished affect, anxiety levels and degree of overprotectiveness have all been indicated by Rustin (1980) as relevant. The family of origin's ability to "separate from the Holocaust and invest anew in their new life and family" is also of import.

Examination of idiosyncratic parental behaviors may also be necessary. Rustin and Lipsig, 1972 reviewed a case "in which Survivor parents who had lost a child during the war, gave their child born after the war the name of the deceased child" (Rustin, 1980). Such instances contribute to extreme identity problems, extreme self and parental expectations and parental over-investment in their offspring. But, it is also imperative to realize that "no generalization... is a safe generalization." (Rustin, 1980)

In sum, specific problems are presented by Survivors and their children. Over-riding religious issues may further complicate the treatment picture. Furthermore, research into this area is scanty, with few controls. It is hoped, however, that this paper will sensitize others to some of the issues in treating this population and further research relative to specific therapeutic techniques.

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